YouthCare HealthChoice Illinois

SUBMIT TO
Utilization Management Department
PHONE 844-289-2264 | FAX 844-989-0154

INTENSIVE IN-HOME SERVICES NOTIFICATION FORM

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID #_____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary_____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with family? ☐ Yes ☐ No

IF THERE IS ANY MISSING INFORMATION, THE FORM MAY BE REJECTED AND SENT BACK.

_____ _____
Clinician Signature Date

_____ _____
Clinician Signature Date

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PLEASE ATTACH IM + CANS and Approval Notification